Arizona Medical Board

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DRAFT MINUTES FOR OFFSITE PLANNING MEETING
Held at 9:30 a.m. on September 8, 2006
Loews Ventana Canyon Resort, 7000 N. Resort Drive, Tucson, AZ

Board Members

Robert P. Goldfarb, M.D., F.A.C.S., Chair
William R. Martin III, M.D., Vice Chair
Douglas D. Lee, M.D., Secretary
Patrick N. Connell, M.D.
Patricia Griffen
Tim. B. Hunter, M.D.
Becky Jordan
Ram R. Krishna, M.D.
Lorraine L. Mackstaller, M.D.
Sharon B. Megdal, Ph.D.
Dona Pardo, Ph.D., R.N.
Paul M. Petelin Sr., M.D.

CALL TO ORDER

The meeting was called to Order at 9:43 a.m.

ROLL CALL

Roll call was taken and the following Board Members were present: Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N. and Paul M. Petelin, Sr., M.D. The following Board Member was not present: Patrick N. Connell, M.D. The following Board Member joined the meeting at 3:09 p.m.: Douglas D. Lee, M.D.

CALL TO PUBLIC

There was no one present for Call to Public.

NON-TIME SPECIFIC ITEMS:

PHYSICIAN ASSISTANT ISSUES:

Robert P. Goldfarb, M.D., FACS stated this is one of the Board's biggest issues lately, especially in terms of medical misjudgments. Dr. Goldfarb stated when patients see a physician assistant they expect the same level of care they would ordinarily receive from the physician. Meeting with the PA once a week is not considered adequate supervision. Physician assistants do not have the expertise and training of a physician and problems arise when there is not appropriate supervision. Timothy C. Miller, J.D. provided an overview of the issues facing the Agency and the issues addressed by the Arizona Regulatory Board of Physician Assistants (PA Board). He stated it is hard to tell if the supervising physician ever sees the patient and to whom the patient belongs. The supervising physician is legally responsible for the activities of the physician assistant even if the physician assistant is practicing independently. In a recent PA Board case a physician assistant saw a patient with significant health issues 16 times without consulting the supervising physician resulting in the patient developing end stage renal disease. Ram R. Krishna, M.D. stated this is concerning and the law is not clear that the supervising physician must be in the same location as the physician assistant. William R. Martin, III, M.D. asked if the physician assistant holds some responsibility for ensuring there is supervision.

Christine Cassetta, Board Legal Advisor stated that while the physician assistant bears some responsibility the supervising physician is ultimately responsible for the patient's care. Mr. Miller stated the Rules are not clear what should be discussed in the statutorily required weekly meeting. Additionally, there are some physician assistants who are practicing independently in very remote locations with the supervising physician in a geographically remote location. There is also some question about what responsibilities supervising physicians delegate to physician assistants and whether those responsibilities are within the supervising physician's scope of practice. Mr. Miller stated there are times when physician assistants do not know what they do not know and therefore do not bring pertinent issues to the supervising physician's attention.

Ms. Cassetta stated by law there is a dependent relationship between a supervising physician and a physician assistant. A supervising physician must provide the Board with a Notice of Supervision (NOS) listing those activities the physician assistant will perform. Some physician assistants also have multiple supervising physician agents who serve as the supervising physician when the delegated supervising physician is not available. Ms. Cassetta clarified that nurse practitioners have a different scope of practice and can practice independently.

Becky Jordan expressed concern that patients living in remote locations may not have access to medical care if physician assistants could not practice in those locations. Ms. Cassetta stated physician assistants can practice in remote locations with the supervising physician in geographically remote locations if there are mechanisms in place for adequate supervision. Ms. Cassetta and Suzann Grabe, Licensing Manager, have made sure the NOS form makes these responsibilities clear.

Timothy B. Hunter, M.D. questioned why a physician would sign on as a supervising physician to a physician assistant not practicing within the same practice. The Board members opined there usually is an economic benefit to the relationship.

Sharon B. Megdal, Ph.D. expressed concern about patients not realizing they are receiving care from someone who does not possess the same level of qualification as a physician and suggested there be some sort of mandatory public disclosure to patients.

Dr. Goldfarb outlined three common settings in which a physician assistant practices.

1. Primary care setting with a supervising physician – In this setting the supervising physician is able to increase the office's financial capabilities because the office is able to bring in more patients and bill a physician's rate for a physician assistant's services. In very busy practices it is almost impossible for the supervising physician to review the charts of every patient. Dr. Goldfarb asked if the Board would expect the supervising physician to review each and every patient with the physician assistant.

2. Surgical physician assistant – In this setting a physician assistant works with a single physician or a few physicians within the practice. There are often more frequent discussions regarding every patient. The Board did not find an issue with this relationship.

3. Physician assistants who work in the hospital setting, such as the emergency department – In this setting a physician assistant may work for one physician who does not see every patient or with multiple physicians in the surgical setting. The one-on-one discussion with the supervising physician may not occur on a frequent basis.

The Board expressed concern that there are patients who are treated by the physician assistant for long periods of time without ever seeing the supervising physician.

Ms. Cassetta clarified that although the statute states the physician assistant and supervising physician must meet once a week there is nothing prohibiting them from meeting more often. Dr. Goldfarb stated there are many physician assistants who are very good and practice well on their own. However there is a lot of confusion among patients regarding who is the physician and who is the assistant.

Dr. Megdal stated that billing at a physician rate for a physician assistant appears to be a scam. While she does not want to over-legislate this issue there should be a mechanism in place for the supervising physician to know exactly which patients were seen by the physician assistant and for what issues. Patients should feel comfortable knowing a supervising physician is also reviewing their case.

Paul M. Petelin, Sr., M.D. stated he agreed the payment schedule for a physician assistant appears to be a scam, but pointed out that with the decreasing rates of reimbursement for office visits it is a system built out of necessity. He also felt a supervising physician should review the majority of patients seen by the physician assistant, especially those presenting with atypical symptoms, on a daily basis. The Board members agreed that a supervising physician does not have to review the files of patients presenting in fairly good health and with minor problems. Ms. Cassetta clarified that if there was an abnormal lab result missed by the physician assistant and the supervising physician both parties would be liable for the error.

Dr. Hunter agreed with Dr. Megdal's suggestion to require a physician assistant to keep a list of patients seen and that outlines which patients presented with atypical symptoms and/or who had abnormal lab results.

Lorraine L. Mackstaller, M.D. agreed there must be daily accountability on the part of the supervising physician. There must be a good check and balance system in place. She also pointed out that some of her patients have confused the physician assistants or nurse practitioners they have seen in the past as a physician. Dr. Hunter agreed and felt there should be full disclosure on the part of the physician assistant. Pat Griffen also agreed disclosure was important. She stated it seems there are a lot of physician assistants who allow their patients to think they are physicians and do not correct patient misperceptions.

Dr. Megdal stated that when establishing new statutes or rules the Board must try to make it clear that the intent is not to restrict the practice of a physician assistant, but rather to ensure appropriate safeguards are in place.

The Board agreed that 1) there should be disclosure regarding who the patient is seeing, 2) there should be daily reporting to the supervising physician on patients who were seen that day with documentation, such as a list of patients and their problems or a progress note, that is signed and dated by the supervising physician. If the supervising physician requires such a list the supervising physician should dictate what he or she would like to see on that list. In practices that are geographically remote this documentation can be transmitted electronically. This is in addition to the weekly face-to-face meeting.

The Board also discussed that in the course of treatment the supervising physician should see the patient at least once to establish a physician-patient relationship. The Board noted with those relationships that are geographically remote the supervising physician will not travel to that location. Some Board members agreed that there are some cases in which the physician assistant saw a patient for a relatively minor procedure.

It would be onerous for a physician to have to see each of these patients. This might be a matter of how much trust a supervising physician has in the physician assistant's competence. Dr. Martin and Dr. Krishna were not in favor of requiring a supervising physician to see all patients at least once. Dona Pardo, Ph.D., R.N. stated that from a lay person's perspective she had a hard time accepting that a supervising physician would never see the patients their physician assistants are seeing. She also stated that she was not sure that having a physician assistant with no supervision in a geographically remote location was better than people in those locations not having any available medical care. Ms. Jordan stated that a physician can delegate authority, but he or she cannot delegate responsibility.

The Board members agreed there needs to be some definition to explain how remote the location of the supervising physician can be.

The Board discussed the issue of physician assistants who are employed by hospitals to assist in surgery and who have multiple supervising physician agents. In this setting the hospital is abusing the system because the physician assistant is assigned to whichever supervising physician agent is in the hospital at the time. However the supervising physician is technically not unavailable. This is also done because it is less expensive to register as a supervising agent than to be a supervising physician. The Board clarified there can be multiple supervising physicians. The Board agreed that if more than one physician wants to supervise a physician assistant they must both be official supervising physicians and not supervising agents. Supervising physician agents should only be used in the true sense of the law. The Board also agreed the fee to become a supervising physician was not onerous as it is a one-time fee and there is no renewal.

The Board clarified that a physician shall supervise no more than two physician assistants at a time.

The Board agreed that it would be recommended, but not required, that a supervising physician physically see the patient at least once during a course of treatment.

Ms. Cassetta informed the Board that the PA Board had the same concerns and the Medical Board is moving in the same direction

MOTION: Sharon B. Megdal, M.D. moved to accept the following standards for physician assistant supervision: 1) One physician can only supervise two physician assistants at one time and cannot supervise multiple physician assistants, 2) It is recommend the supervising physician see the patient at least once during a course of treatment, especially when there is the need for ongoing medical care, 3) When a physician assistant sees a patient the patient is the responsibility of the supervising physician, 4) The Board recommends the supervising physician have in place a system for daily review of a list of patients the physician assistant saw or the progress note that is signed by the physician.
SECONDED: Timothy B. Hunter, M.D.
Vote: 10-0

Dr. Megdal stated she would like to see a public education plan put in place once these statute and rule changes have been put in place. Dr. Martin clarified for the record that he believed no care was better than unsupervised care in remote settings.

EXPERT WITNESS TESTIMONY:
Dr. Goldfarb provided the Board members with some background on this issue. He stated there are some physicians who make money by testifying in medical malpractice cases and who fraudulently testify about the standard of care. The American Association of Neurological Surgeons investigated a physician who did this and kicked the physician out the Association. The case was appealed to the Court of Appeals and the judge ultimately found in favor of the Association and noted this was the role of a specialty association. Dr. Goldfarb stated that based on legal advice he has received from the Attorney General's Office falsely testifying is not a violation of the Medical Practice Act as it is currently written. Several states including Mississippi and South Carolina have recently amended their statutes to make expert witness testimony the practice of medicine. He asked the Board members if they would be amenable to making a similar statutory change.

Dr. Hunter clarified that false expert witness testimony is not considered to be a violation of the Medical Practice Act. Ms. Cassetta confirmed. She also informed the Board that the Mississippi legislation was based in part on out of control tort awards by juries in Mississippi and that this does not seem to be a problem in Arizona. She stated her concern over who would be tasked with deciding whether a physician's testimony was false versus testimony that was wrong, but believed to be true by the physician.

Dr. Martin stated some specialty societies have taken this issue on and have taken action against the physicians in their societies. Dr. Hunter stated he preferred the Board not take on this issue and would prefer the courts sort it out during the course of individual hearings. Dr. Martin found it distasteful that physicians licensed in other states could come to Arizona and provide false testimony.

Ms. Cassetta stated that by developing this type of legislation the Board may face repercussions such as being unable to retain medical consultants to review its cases and testify at formal hearings.

Dr. Krishna stated he would prefer a law that would require all physicians who testify in Arizona be licensed in this State. Ms. Cassetta stated last year the legislature clarified that a physician should be licensed in this state or another state and be of the same specialty if opposing another physician's testimony.

The Board members agreed not to take any action on this matter.

PHP FUTURE DIRECTION:
Mr. Miller stated since the last Offsite Board Meeting the Agency has developed the Physician Health Program and operates it internally. He asked for Board input regarding whether it should continue to operate as is, merge with the Monitored Aftercare Program or develop further by merging with an umbrella group that includes hospitals. Mr. Miller preferred PHP, once it is more fully developed, merge into MAP and contract the combined program to an outside vendor. While a global program that includes hospitals has a number of benefits, he stated the Board would lose control of the program.

Ms. Cassetta clarified that the Board has the authority over with physicians who have physical or behavioral health problems that may impact patient care. However, the Board does not have authority over those physicians whose problems does not impact patient care because participation in the program is voluntary and, without any risk to the public the Board has no authority over the physician's conduct.

Dr. Krishna felt PHP should not be done in the hospital setting because physician confidentiality is at risk in this setting. He would prefer PHP merge with MAP. Dr. Megdal stated she did not know why this issue was before the Board now considering the Board is letting a Request for Proposal (RFP) for the current MAP contract. Until the Board has more experience in dealing with these physicians she felt the Board should not make any decisions at this time. Dr. Martin felt the Board should start planning for the future and develop some conceptual framework for the program while it gathers information. He would prefer a structure in which the Arizona Medical Board is the top tier and that hospitals could refer physicians to its program, but would maintain control over the program.

Mr. Miller informed the Board that the current RFP would expire in a year and a half with the option renewing the contract on a yearly basis for the next three years.

Dr. Martin suggested the Board develop a subcommittee and include stakeholders to identify the different facets, look at other state statutes and come up with a plan that could be presented to the Board at a later time. The Board members suggested looking for another state to use as an example for how to operate our own program.

Dr. Hunter confirmed that the agency has knowledge of who is in the program and maintained the importance of knowing who is participating.

The Board asked Ms. Cassetta and Mr. Miller to research the issue and bring it back to the Board at a later date.

COMMITTEE TO COMMUNICATE PHP TO PHYSICIANS THROUGHOUT THE STATE:
Dr. Martin stated that the creation of the Physician Health Program has benefited both the physicians and public in the State. In the past the Board needed to find a way to address physician health issues while at the same time determining whether discipline was warranted. Based on conferences he has attended and current literature on physician health issues he felt the Board should take the lead in communicating physician health concerns.

Dr. Martin stated that physicians are 1.7 times (males) and 2.4 times (females) more likely to commit suicide than non healthcare professionals. Physicians tend to have more stressors and barriers to behavioral health care. The Physician Health Program is a good tool to help physicians, but more physicians and the public need to know that it exists. The Board should be known as more than a disciplinary Board and also be known for its mechanisms to help and rehabilitate physicians.

Dr. Krishna complemented Dr. Martin for his initiative and felt the Board should start at the grass roots level to inform physicians of the Board's service. Mr. Miller stated he has been speaking at various hospitals to promote the Program and encourage physicians to come forward. Each hospital where he has spoken has referred at least one physician to the Program. These types of talks are a good way of relaying the message that the Board can help them without taking discipline. Mr. Miller agreed the Board need to encourage physicians to come forward and not try to treat their issues on their own.

Dr. Megdal stated the Board has discussed the issue of becoming more proactive in the past, but there has not been much work done in this area other than placing articles on the website. She suggested broadening its reach to television, etc.

Dr. Goldfarb suggested the Board members contact him if they are willing to serve on a subcommittee to work with Staff on this issue.

William R. Martin, III, M.D. left the meeting at 1:30 p.m.

BOARD MEMBER TRAINING:
Ms. Cassetta provided the Board members with materials regarding training issues. She highlighted the issue of time management when presenting formal interviews. She suggested the presenting Board member could ask the physician if he or she agreed with the facts as presented by Staff. The Board members agreed to limit the time for initial questioning by the presenting Board member to 15 minutes. Ms. Cassetta also informed the Board members they have the authority to control the interview by stopping physicians from going off track an asking them to answer the question at hand.

Dr. Goldfarb directed Staff to develop a system for showing the Board members when 15 minutes has elapsed.

Dr. Petelin pointed out there are unusual cases, such as when there is more than one patient, where more than 15 minutes is needed. Ms. Cassetta suggested focusing the questions on the key issues.

Ms. Cassetta informed the Board that the standard of care and deviation need to be identified in cases where there is a (q) or (ll) violation.

She reminded the Board members to ask questions of its consultant rather than to each other. She also reminded Board members of decorum during meetings such as side conversations. These conversations can offend the physician, the complainant or others in the audience. She also

asked that if possible Board members not leave the room during the formal interview because they are not privy to all the questioning. If a Board member has to leave, she asked they use own judgment regarding the amount time spent out of the room before voting.

Ms. Jordan asked about the count on the abstaining votes. Ms. Cassetta informed the Board that abstentions should only be used in limited circumstances. They are viewed as going with the majority. Dr. Megdal clarified that remaining silent during a voice vote is counted as a yes, but abstaining from the vote is not.

Ms. Cassetta addressed the issue of reviewing outside materials not provided by Board Staff. She stated the Board Members should only review materials at hand. If a Board Member reviews other materials in his or her preparation the Board Member should provide those materials to Board Staff so they can be distributed to the other Board members and to the physician. Ms. Cassetta encouraged the Board members to not seek advice from other physicians in a particular field. If they need more information Board Members should request that information from Staff. The Board Members expressed concern with this advice and believe they must conduct outside research in order to be prepared for the meeting, especially when presenting cases outside their field of practice. Ms. Cassetta advised them to watch how far they go with their research and what materials they use. If a Board Member finds a piece of literature that it helps make a definitive decision he or she must share it with Staff. She asked the Board Members to limit outside research to preliminary reviews of literature, etc. If the Board is not getting enough from the consultants Ms. Cassetta asked them to inform Dr. Nanney so he can direct the consultant to provide a more thorough review. Ms. Cassetta stated the key is for the Board Member to not have any information that anyone else has.

Dr. Mackstaller stated that the Board is sitting in judgment of their peers and the physician in question has the right to expect the Board to have a certain degree of knowledge regarding his or her field of practice. She stated there have been multiple cases in which the consultant's response is so brief that it requires her to do more research before presenting a case.

Dr. Goldfarb asked if there is legal problem with a Board member using information gained outside of the Board's investigation. Ms. Cassetta stated there might be a problem because that Board member would not be on even footing with the other Board members. Dr. Megdal reminded the Board members that during the preparation time Board members do not make a decision. The other Board members agreed and have found that during the course of the interview their views of the case often change greatly based on the physician testimony. Ms. Cassetta advised the Board Members to prepare as needed, but if they find information might go to the ultimate outcome of the case they must provide it to Staff so it can be shared with the Board's medical consultant and the physician.

Dr. Megdal asked for clarification on the extent the Board members needed to review the record when changing the Findings of Fact, Conclusions of Law or Order on a case that goes to formal hearing. Ms. Cassetta stated the Board is not required to read the transcripts and all exhibits from formal hearing cases word for word because if the Board was required to do so there would be no need to send the case to the Administrative Law Judge (ALJ) to make the recommended decision. However, if the Board would like to change a fact finding the Board must cite to the record. Following the Board meeting Ms. Cassetta must write a letter to the ALJ explaining any fact finding changes with point by point references. The Board is free to change the conclusions of law without citing to the record, but must explain why they are making the change. The Board is also the ultimate decision maker on the sanction, but must explain any change to the sanction.

Dr. Pardo asked if new Board members receive an orientation with this kind of information. Ms. Cassetta stated that she and Staff typically go over the basics, but some of the legal issues can be overwhelming. These issues often have no meaning until the new Board members see them in operation.

Dr. Goldfarb asked about last minute filings that are often provided by the physician or his or her attorney and whether the Board could establish a cut off date. Ms. Cassetta stated the Board could set the information aside and is not required to review it. However, this last minute information can often change the entire outcome of the case. Dr. Megdal stated that sometimes it appears as though attorneys are using the Board by putting the Board members on the spot with their submission of last minute materials. Even though it plays havoc with the agenda schedule, Staff can determine whether the case should be pulled and placed on a future agenda. Ms. Cassetta stated that the Board cannot refuse to accept new information, but is not obligated to review it. The Board asked Staff to review the formal interview letter and determine if they can require the other side request a continuance based on the new information. Dr. Hunter stated he would prefer that Staff not distribute materials received late.

FUTURE BOARD POLICY:

SUBCOMMITTEE ON ISSUE OF WRONG LEVEL/WRONG SITE SURGERY:

Dr. Krishna stated he is not recommending forming a subcommittee on this issue, but would like the Board to develop some consistency with their actions in these cases. Oftentimes mitigating circumstances make it difficult to have consistency. He felt that unless the mitigating circumstances were extraordinary the Board should develop a standard for how to adjudicate these types of cases. Dr. Krishna provided a hypothetical example of a case involving a wrong level surgery, but the physician was no longer practicing. The Board members agreed that a physician no longer practicing is not a mitigating factor.

Dr. Mackstaller stated it can be difficult to apply issues of wrong site deviations to other areas of practice, such as ophthalmology. The Board's decisions in these cases can make it difficult for physicians to feel comfortable delegating common tasks to nurse practitioners or technicians. Dr. Goldfarb stated there are items that are specifically within the purview of a nurse practitioner or technician and that are not the physician's responsibility. However, even in those cases, there needs to be a system of checks and balances in place and when these checks and balances are not done, the physician is responsible.

Dr. Petelin stated that the Board has seen a number of these types of cases involving a technician and it appears there will be more cases like them. Dr. Hunter stated that as a general rule the physician is responsible. Dr. Megdal reminded the Board members there is a human component to all the cases presented to the Board and the Board often has differing opinions.

Ms. Cassetta stated that one of the mitigating factors in the Disciplinary Rules is the setting in which the physician practices and how much control the physician has over the situation.

Dr. Goldfarb stated that the ultimate issue is delegation of responsibility and who is at fault in the end. Mr. Miller stated that Staff has received conflicting opinions from the Board and this has created some difficulty for the Staff Investigational Review Committee (SIRC) when making recommendations to the Board. The Board members also stated the standard of practice in the community, especially with ophthalmology, is not equivalent to the standard of care. Dr. Mackstaller stated there has to be a way to transmit what the Board considers to be the standard of care to ophthalmologists and that the Board will hold them to that standard. It is the physician's responsibility to physically verify the readings taken by a technician. Dr. Goldfarb stated that the standard of care for any specialty is to operate on the correct organ and do the correct surgery. Physicians must be held liable when this standard is not met. Dr. Pardo stressed the importance of issuing consistent actions in order to pass the message along to the physician community. Dr. Megdal expressed a desire, with public information in mind, to amend its statutes and rules and publish its opinion publicly.

Ms. Jordan asked the Board members to state their reasons for issuing discipline without saying "for consistency."

EARLY EDUCATION FOR DISRUPTIVE PHYSICIANS – This item was not discussed. Dr. Krishna stated the issue was covered under the Board's earlier PHP discussion.

Sharon B. Megdal, M.D. left the meeting at 2:35 p.m.

ON-LINE TESTING ON STATE STATUTES AND RULES:
Lisa McGrane, Investigational Review Manager provided the Board with an overview of the program Staff developed in addition to example questions for on-line physician testing. This is a program the Board requested in the past. Ms. McGrane asked for Board Member feedback and direction for how the Board would like to see the project progress. Overall the Board approved the program and was very complimentary of Staff's work. Dr. Mackstaller said the questions asked in the test were helpful and asked that Staff develop a process to communicate it to physicians throughout the State. She also suggested Staff include a few of the test questions in each issue of the *Primum* newsletter. The Board Members asked if the Board could require physicians to take the test as a condition of licensure. Ms. Cassetta stated that a statutory change would be required to make the test a condition of licensure.

MOTION: Dona Pardo, Ph.D., R.N. moved to change the current statute to require the on-line test as a condition of licensure.
SECONDED: Ram R. Krishna, M.D.
VOTE: 9-0

In the interim the Board Members suggested Staff place a link to the on-line testing program on the license renewal form and encourage physicians to take the test.

The Board Members discussed awarding continuing medical education (CME) credit for taking the test. Some Board members agreed the CME credit could be a draw to encourage more physicians to take the test. Dr. Pardo disagreed and stated that knowing the statutes is a basic requirement of any profession and should not be rewarded with CME credit. Ms. Cassetta also stated that giving CME credit for the test would require a Rule change.

The Board Members stressed the importance of communicating the on-line testing program to medical school students, interns and residents.

IMPLEMENTATION OF NON-DISCIPLINARY CME:
Mr. Miller explained the Board now has the authority to issue non-disciplinary CME. In the past the Board sometimes struggled with wanting to issue CME, but not wanting to discipline. Mr. Miller presented the following options for issuing non-disciplinary CME:

1. Issuing non-disciplinary CME on its own
2. Combine discipline with non-disciplinary CME
3. Combine non-disciplinary CME with an advisory letter.

Ms. Cassetta stated the Board has the option of dismissing a case, issuing an advisory letter, issuing non-disciplinary CME, issuing a combination of non-disciplinary CME with an advisory letter or issuing discipline with CME (probationary or non-probationary). If the Board wanted to issue non-disciplinary CME, the Board could order it and compel it. In this case the physician would be required to take it. The Board agreed with this approach. The Board also asked that if SIRC recommends non-disciplinary CME as the only case resolution that these cases be placed on the Board's agenda in the same way advisory letters are currently listed.

PRESCRIPTION MONITORING PROGRAM:
Mr. Miller stated the Pharmacy Board is establishing a program to monitor prescription drugs authorized by physicians. Currently pharmacies are dumping their data into a centralized database that identifies the physician who prescribed the medication, the patient, and the medication prescribed. This provides a physician the opportunity to see his or her patient's prescribing history. It also allows medical boards and law enforcement to search for a physician's prescribing history. In Nevada there are some measures in place to ensure there is no abuse of the system, such as requiring the medical board to have an open investigation against the physician. There is also a safeguard to ensure the physician querying the database is a licensed physician.

Mr. Miller stated in Arizona there is an oversight committee to oversee the program and make sure it is monitored appropriately and in accordance with the law. The Pharmacy Board is proposing each physician pay a $10 fee for a prescription card. That fee would be used to fund the Prescription Monitoring Program. The other states that have implemented the Program have received letters from their respective Attorney General that the Program is HIPAA compliant.

Lorraine L. Mackstaller, M.D. left the meeting at 3:06 p.m.

Dr. Petelin asked if there was a flow of information that would provide a mechanism for the Prescription Monitoring Program to notify the physician if the patient was obtaining the same or similar prescriptions from other physicians. Mr. Miller stated that this is currently in place in Nevada.

Douglas D. Lee, M.D. joined the meeting at 3:09 p.m.

Mr. Miller informed the Board he has been asked to serve on the Prescription Monitoring Program's oversight committee and asked for the Board's input regarding his responsibility on the committee. Dr. Goldfarb asked Mr. Miller to sit on the committee, gain more information, and provide the Board with more information as he learns more about it. In theory, the Board members support the implementation of the Program and Mr. Miller's role on the committee.

FUTURE DIRECTION/DISCUSSION ITEMS:
Dr. Petelin stated he found it troubling that the Board has not seen any malpractice cases involving physicians practicing at the Mayo Clinic. It is his understanding that settlements involving these physicians have only named the hospital and not the physicians involved. By doing this they are circumventing the process for reporting to the National Practitioner's Data Bank (NPDB) and to the Board. Dr. Goldfarb asked Ms. Cassetta to look into the legalities of this to determine if this is still the practice. Dr. Nanney stated that if the plaintiff's attorney agrees to accept a lump sum payment made on behalf on the facility the physicians involved would not be named. The Board members agreed this was not fair.

Mr. Miller stated that the Board has experienced some problems with hospitals not fulfilling their statutory requirement for reporting physicians to the Board. Mr. Miller will be discussing this issue at a future hospital administrator's meeting. Ms. Cassetta clarified that a hospital is only required to report if it takes an action that affects the physician's privileges. Other physicians are required to report any information that appears to show a physician is or may be guilty of unprofessional conduct, medically incompetent, or mentally or physically unable to safely engage in the practice of medicine. Dr. Goldfarb asked Mr. Miller to draft a letter to send to hospital administrators reminding them of their responsibilities.

The meeting was adjourned at 3:22 p.m.

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Timothy C. Miller, J.D., Executive Director